Testimony of the Connecticut ENT Society
The Connecticut Society of Eye Physicians
CT Dermatology and Dermatologic Surgery Society
On
SB 980, An Act Concerning Certificates of Need
Presented to the Public Health Committee
By
Debbie Osborn

February 27, 2009

Good morning Senator Harris, Representative Ritter, and distinguished members of the Public Health Committee. My name is Debbie Osborn, I am the Executive Director of CT ENT Society, CT Society of Eye Physicians and the CT Dermatology and Dermatologic Surgery Society, representing over 700 physicians in support of SB980, with some amendments to provide exemptions for CT scanners falling under eight hundred thousand dollars.

We have provided for you four documents:

The first marked Exhibit "A" is the September 15, 2008 Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission Before the Illinois Task Force on Health Planning Reform. In a nutshell, according to DOJ and FTC, Certificate of Need laws are inherently anti-competitive and no longer serve the need for which they were intended.

The second marked Exhibit "B" is a document released in October by Commissioner Christine Vogel and the Office of Health Care Access with proposed changes to Connecticut 's Certificate of Need law. Please notice that this document includes the current proposed changes in Senate Bill 980, AN ACT CONCERNING CERTIFICATES OF NEED. Also, please notice that the CURRENT proposed changes in Senate Bill 980 do NOT include ALL of the changes Commissioner Vogel and OCHA proposed in their release. The Connecticut Ear Nose & Throat Society supports the changes originally recommended by OCHA in Exhibit A and that also address the concerns of the federal government in Section 5(c) by limiting a

CON to CT scanners whose value is in excess of $800,000 – currently there is no bar or limit.

The third marked Exhibit "C" is the June 2, 2008 letter from the Connecticut State Medical Society to OCHA showing broad support within organized medicine for needed changes to our State's CON law.

Finally, the fourth marked Exhibit "D" is the February 11, 2009 letter from OCHA to the Connecticut State Medical Society proposing a closed meeting on Tuesday, March 10 including representation from the State Medical Society and specialty representation from ENT, Urology, Neurology and Orthopedics. The invitation letter makes no mention of dental medicine or oral surgery, even though a public hearing was held two years ago to consider their concerns with regard to Certificate of Need and limited CT scans applicable to restorative dentistry. It also did not mention representation from Radiology. Dr. Steven Levine of Trumbull will personally represent the Connecticut Ear Nose & Throat Society at this meeting, and any subsequent meetings should they be necessary.

Clearly the current proposed changes in SB 980 are inadequate with regard to the concerns of the U.S. Department of Justice, the Federal Trade Commission, and organized medicine. We ask this Committee to consider amending SB980 to reflect these concerns. Thank you for your time and consideration.

Exhibit A

Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission Before the Illinois Task Force on Health Planning Reform

September 15, 2008[1]

The Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission appreciate the opportunity to share our views on the impact of Certificate-of-Need ("CON") laws on health care markets.[2]

The Antitrust Division and the FTC (together, the Agencies) have investigated and litigated antitrust cases in markets across the country involving hospitals, physicians, ambulatory surgery centers, stand-alone radiology programs, medical equipment, pharmaceuticals, and other health care goods and services. In addition to this enforcement, we have conducted hearings and undertaken research on various issues in health care competition. For example, in 2003, we conducted 27 days of hearings on competition and policy concerns in the health care industry, hearing from approximately 250 panelists, eliciting 62 written submissions, and generating almost 6,000 pages of transcripts.[3] As a result of that effort, the Agencies jointly published an extensive report in July 2004 entitled, *Improving Health Care: A Dose of Competition*.[4] We regularly issue informal advisory letters on the application of the antitrust laws to health care markets, and periodically issue reports and general guidance to the health care community. Through this work, we have developed a substantial understanding of the competitive forces that drive innovation, costs, and prices in health care.

The Agencies' experience and expertise has taught us that Certificate-of-Need laws impede the efficient performance of health care markets. By their very nature, CON laws

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[1] This statement draws from testimony delivered on behalf of the Antitrust Division to the General Assembly and Senate of the State of Georgia on February 23, 2007; to the Committee on Health of the Alaska House of Representatives on January 31, 2008; and to the Florida Senate Committee on Health and Human Services Appropriations on March 25, 2008. It also draws from testimony delivered on behalf of the Federal Trade Commission to the Committee on Health of the Alaska House of Representatives on February 15, 2008 and to the Florida State Senate on April 2, 2008.

[2] This statement responds to an invitation from Illinois State Senator Susan Garrett, co-chair of the Illinois Task Force on Health Planning Reform, dated June 30, 2008.

[3] This extensive hearing record is largely available at http://www.ftc.gov/bc/healthcare/research/healthcarehearing.htm.

[4] FEDERAL TRADE COMMISSION AND THE DEPARTMENT OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (July 2004), *available at* http://www.usdoj.gov/atr/public/health_care/204694.htm (hereinafter A DOSE OF COMPETITION).

create barriers to entry and expansion to the detriment of health care competition and consumers. They undercut consumer choice, stifle innovation, and weaken markets' ability to contain health care costs. Together, we support the repeal of such laws, as well as steps that reduce their scope.

We have also examined historical and current arguments for CON laws, and conclude that such arguments provide inadequate economic justification for depriving health care consumers of the benefits of competition. To the extent that CONs are used to further non-economic goals, they impose substantial costs, and such goals can likely be more efficiently achieved through other mechanisms. We hope you will carefully consider the substantial costs that CON laws may impose on consumers as you consider eliminating or otherwise amending Illinois's CON requirements.

I. Scope of Remarks

Although we do not intend to focus on specific aspects of the CON program in Illinois, we are generally familiar with the issues before you and recognize them as issues that CON laws present in other states and markets. Also, please note that it is not the intent of the Agencies to "favor any particular procompetitive organization or structure of health care delivery over other forms that consumers may desire. Rather, [our] goal is to ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices . . ."[5] Our mission is to preserve and promote consumer access to the benefits of competition, rather than any particular marketplace rival or group of rivals.

II. Importance of Competition and the Harm Caused by Regulatory Barriers to Entry

A. The Benefits of Competition in Health Care

Our concerns about the harm from CON laws are informed by one fundamental principle: market forces tend to improve the quality and lower the costs of health care goods and services. They drive innovation and ultimately lead to the delivery of better health care. In contrast, over-restrictive government intervention can undermine market forces to the detriment of health care consumers and may facilitate anticompetitive private behavior.

In our antitrust investigations we often hear the argument that health care is "different" and that competition principles do not apply to the provision of health care services. However, the proposition that competition cannot work in health care is not

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[5] U.S. Department of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care, August 1996, Introduction, at 3, *available at* http://www.usdoj.gov/atr/public/guidelines/1791.htm.

supported by the evidence or the law. Similar arguments made by engineers and lawyers – that competition fundamentally does not work and, in fact is harmful to public policy goals – have been rejected by the courts, and private restraints on competition have long been condemned.[6] Beginning with the seminal 1943 decision in *American Medical Association v. United States*, the Supreme Court has come to recognize the importance of competition and the application of antitrust principles to health care.[7] The Antitrust Division and the Federal Trade Commission have worked diligently to make sure that barriers to that competition do not arise.

During our extensive health care hearings in 2003, we obtained substantial evidence about the role of competition in our health care delivery system and reached the conclusion that vigorous competition among health care providers "promotes the delivery of high-quality, cost-effective health care."[8] Specifically, competition results in lower prices and broader access to health care and health insurance, while non-price competition can promote higher quality.[9]

Competition has also brought consumers important innovations in health care delivery. For example, health plan demand for lower costs and "'patient demand for a non-institutional, friendly, convenient setting for their surgical care'" drove the growth of Ambulatory Surgery Centers.[10] Ambulatory Surgery Centers offered patients more convenient locations, shorter wait times, and lower coinsurance than hospital departments.[11] Technological innovations, such as endoscopic surgery and advanced anesthetic agents, were a central factor in this success.[12] Many traditional acute care hospitals have responded to these market innovations by improving the quality, variety, and value of their own surgical services, often developing on- or off-site ambulatory surgery centers of their own.

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[6] *See, e.g., F.T.C. v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411 (1990); *National Society of Professional Engineers v. U.S.*, 435 U.S. 679 (1978).

[7] 317 U.S. 519, 528, 536 (1943) (holding that a group of physicians and a medical association were not exempted by the Clayton Act and the Norris-LaGuardia Acts from the operation of the Sherman Act, although declining to reach the question whether a physician's practice of his or her profession constitutes "trade" under the meaning of Section 3 of the Sherman Act).

[8] A DOSE OF COMPETITION, Executive Summary, at 4.

[9] *Id.*; *see also id.*, Ch. 3, §VIII.

[10] Id., Ch. 3 at 25.

[11] MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY § 2F, at 140 (2003), *available at* http://www.medpac.gov/publications/congressional_reports/Mar03_Entire_report.pdf.

[12] A DOSE OF COMPETITION, Ch. 3 at 24.

This type of competitive success story has occurred often in health care in the areas of pharmaceuticals, urgent care centers, limited service or "retail" clinics, and the development of elective surgeries such as LASIK, to name just a few. Without private or governmental impediments to their performance, we can expect health care markets to continue to deliver such benefits.

B. CON Laws Create Barriers to Beneficial Competition

CON laws are a regulatory barrier to entry, which, by their nature, are an impediment to health care competition. Accordingly, in *A Dose of Competition*, we urged states to rethink their CON laws.[13]

1. Original Cost-Control Reasons For CON Laws No Longer Apply

We made that recommendation in part because the original reason for the adoption of CON laws is no longer valid. Many CON programs trace their origin to a repealed federal mandate, the National Health Planning and Resources Development Act of 1974, which offered incentives for states to implement CON programs. At that time, the federal government and private insurance reimbursed health care charges predominantly on a "cost-plus" basis, which provided incentives for over-investment. There was concern that, because patients are usually not price-sensitive, providers engaged in a "medical arms race" by unnecessarily expanding their services to offer the perceived highest-quality services, allegedly driving up health care costs.[14] The hope was that CON laws would provide a counterweight against that skewed incentive.

Thus, it is important to note that:

- CON laws were not adopted as a means of cross-subsidizing care;
- CON laws were not adopted to have centralized planning of health care markets as an end in itself;
- CON laws were not adopted to supplant or augment state-law licensing regulations designed to protect the health and safety of the population from poor-quality health care.

Since the 1970s, the reimbursement methodologies that may in theory have justified CON laws initially have significantly changed. The federal government, as well as private third-party payors, no longer reimburse on a cost-plus basis. In 1986, Congress repealed the

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[13] A DOSE OF COMPETITION, Executive Summary at 22.

[14] *See* A DOSE OF COMPETITION, Ch. 8 at 1-2.

National Health Planning and Resources Development Act of 1974. And health plans and other purchasers now routinely bargain with health care providers over prices. Essentially, government regulations have changed in a way that eliminates the original justification for CON programs.[15]

CON laws also appear to have generally failed in their intended purpose of containing costs. Numerous studies have examined the effects of CON laws on health care costs,[16] and the best empirical evidence shows that "on balance . . . CON has no effect or actually increases both hospital spending per capita and total spending per capita."[17] A recent study conducted by the Lewin Group for the state of Illinois confirms this finding, concluding that "the evidence on cost containment is weak," and that using "the CON process to reduce overall expenditures is unrealistic."[18]

2. CON Laws Impose Additional Costs and May Facilitate Anti-Competitive Behavior

Not only have CON laws been generally unsuccessful at reducing health care costs, but they also impose additional costs of their own. First, like any barrier to entry, CON laws interfere with the entry of firms that could otherwise provide higher-quality services than

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[15] A DOSE OF COMPETITION, Ch. 8 at 1-6.

[16] A DOSE OF COMPETITION, Ch. 8 at 1-6; CHRISTOPHER J. CONOVER & FRANK A. SLOAN, EVALUATION OF CERTIFICATE OF NEED IN MICHIGAN, CENTER FOR HEALTH POLICY, LAW AND MANAGEMENT, TERRY SANFORD INSTITUTE OF PUBLIC POLICY, DUKE UNIVERSITY, A REPORT TO THE MICHIGAN DEPT. OF COMMUNITY HEALTH, 30 (May 2003); David S. Salkever, *Regulation of Prices and Investment in Hospital in the United States*, in 1B Handbook of Health Economics, 1489-90 (A.J. Culyer & J.P. Newhouse eds., 2000) ("there is little evidence that [1970's era] investment controls reduced the rate of cost growth."); Washington State Joint Legislative Audit and Review Committee (JLARC), Effects of Certificate of Need and Its Possible Repeal, *I* (Jan. 8, 1999) ("CON has not controlled overall health care spending or hospital costs."); DANIEL SHERMAN, FEDERAL TRADE COMMISSION, THE EFFECT OF STATE CERTIFICATE-OF-NEED LAWS ON HOSPITAL COSTS: AN ECONOMIC POLICY ANALYSIS, iv, 58-60 (1988) (concluding, after empirical study of CON programs' effects on hospital costs using 1983-84 data on 3,708 hospitals, that strong CON programs do not lead to lower costs but may actually increase costs); MONICA NOETHER, FEDERAL TRADE COMMISSION, COMPETITION AMONG HOSPITALS 82 (1987) (empirical study concluding that CON regulation led to higher prices and expenditures); KEITH B. ANDERSON & DAVID I. KASS, FEDERAL TRADE COMMISSION, CERTIFICATE OF NEED REGULATION OF ENTRY INTO HOME HEALTH CARE: A MULTI-PRODUCT COST FUNCTION ANALYSIS (1986) (economic study finding that CON regulation led to higher costs, and that CON regulation did little to further economies of scale).

[17] *See* CONOVER & SLOAN, REPORT TO MICHIGAN, *supra* note 15, at 30.

[18] The Lewin Group, *An Evaluation of Illinois' Certificate of Need Program*, prepared for the Illinois Commission on Government Forecasting and Accountability (February 15, 2007), at 31 (hereinafter Lewin Group).

those offered by incumbents.[19] This may tend to depress consumer choice between different types of treatment options or settings,[20] and it may reduce the pressure on incumbents to improve their own offerings.[21]

Second, CON laws can be subject to various types of abuse, creating additional barriers to entry, as well as opportunities for anticompetitive behavior by private parties. In some instances, existing competitors have exploited the CON process to thwart or delay new competition to protect their own supra-competitive revenues. Such behavior, commonly called "rent seeking," is a well-recognized consequence of certain regulatory interventions in the market.[22] For example, incumbent providers may use the hearing and appeals process to cause substantial delays in the development of new health care services and facilities. Such delays can lead both the incumbent providers and potential competitors to divert substantial funds from investments in such facilities and services to legal, consulting, and lobbying expenditures; and such expenditures, in turn, have the potential to raise costs, delay, or – in some instances – prevent the establishment of new facilities and programs.[23]

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[19] A DOSE OF COMPETITION, Ch. 8 at 4 (citing *Hosp. Corp. of Am.*, 106 F.T.C. 361, 495 (1985) (Opinion of the Commission) (stating that "CON laws pose a very substantial obstacle to both new entry and expansion of bed capacity in the Chattanooga market" and that "the very purpose of the CON laws is to restrict entry")).

[20] With regard to hospital markets, *see, e.g.*, UNITED STATES DEPT. OF HEALTH AND HUMAN SERVICES, FINAL REPORT TO THE CONGRESS AND STRATEGIC IMPLEMENTING PLAN REQUIRED UNDER SECTION 5006 OF THE DEFICIT REDUCTION ACT OF 2005 (2006), *available at* http://www.cms.hhs.gov/PhysicianSelfReferral/06a_DRA_Reports.asp (reporting at specialty hospitals a "quality of care at least as good as, and in some cases better than, care provided at local competitor hospitals" for cardiac care, as well as "very high" patient satisfaction in cardiac hospitals and orthopedic specialty hospitals) (citations omitted). In addition, specialty hospitals appear to offer shorter lengths of stay, per procedure, than peer hospitals. *See also* MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS: PHYSICIAN-OWNED SPECIALTY HOSPITALS, vii (Mar. 2005), *available at* http://www.medpac.gov/documents/Mar05_SpecHospitals.pdf (hereinafter MEDPAC).

[21] *See, e.g.*, MEDPAC, *supra* note 19, at 10 (observing both administrative improvements – "Some community hospital administrators admit that competition with specialty hospitals has had some positive effects on community hospitals' operations" – and other qualitative improvements – "We heard several examples of constructive improvements sparked by the entrance of a specialty hospital into a market, including extending service hours, improving operating room scheduling, standardizing the supplies in the operating room, and upgrading equipment.").

[22] Paul Joskow and Nancy Rose, *The Effects of Economic Regulation*, *in* 2 HANDBOOK OF INDUSTRIAL ORGANIZATION (Schmalensee and Willig, eds., 1989).

[23] *See, e.g., Armstrong Surgical Ctr., Inc. v. Armstrong County Mem'l Hosp.*, 185 F.3d 154, 158 (3rd Cir. 1999) (an ambulatory surgery center alleged that a competing hospital had conspired with nineteen of its physicians to make factual misrepresentations as well as boycott threats to the state board, allegedly causing the board to deny the center its CON); *St. Joseph's Hosp., Inc. v. Hosp. Corp. of America*, 795 F.2d 948 (11th Cir. 1986) (a new hospital applying for a CON alleged that an existing competitor submitted false information to the CON board; that the board relied on that information in denying the CON; and that the

Moreover, much of this conduct, even if exclusionary and anticompetitive, may be shielded from federal antitrust scrutiny, because it involves protected petitioning of the state government.[24] During our hearings, we gathered evidence of the widespread recognition that existing competitors use the CON process "to forestall competitors from entering an incumbent's market."[25]

In addition, incumbent providers have sometimes entered into anticompetitive agreements that were facilitated by the CON process, if outside the CON laws themselves. For example:

- In 2006, the Antitrust Division alleged that a hospital in Charleston, West Virginia used the threat of objection during the CON process, and the potential ensuing delay and cost, to induce another hospital seeking a CON for an open heart surgery program not to apply for it at a location that would have well served Charleston consumers.[26] The hospital eventually entered into a consent decree with the Antitrust Division (without a trial on the merits) which prohibited the hospital from taking actions that would restrict other health care facilities from developing cardiac surgery services.[27]

- In another case from West Virginia, the Antitrust Division alleged that two closely competing hospitals agreed to allocate certain health care services among themselves.[28] The informal urging of state CON officials led the hospitals to agree that just one of the hospitals would seek approval for an open heart surgery program, while the other would seek approval to provide cancer treatment services.[29] These hospitals also entered into a consent

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defendants also acted in bad faith to obstruct, delay, and prevent the hospital from obtaining a hearing and later a review of the adverse decision).

[24] *Eastern Rail. Pres. Conf. v. Noerr Motor Frgt., Inc.*, 365 U.S. 127 (1961).

[25] A DOSE OF COMPETITION, Executive Summary at 22.

[26] *U.S. v. Charleston Area Med. Ctr., Inc.*, Civil Action 2:06 -0091 (S.D.W.Va. 2006), *available at* http://www.usdoj.gov/atr/cases/f214400/214477.htm.

[27] Justice Department Requires West Virginia Medical Center to End Illegal Agreement (Feb. 6, 2006), *available at* http://home.atrnet.gov/subdocs/214463.htm.

[28] *U.S. v. Bluefield Regional Medical Center, Inc.*, 2005-2 Trade Cases ¶ 74,916 (S.D. W.Va. 2005).

[29] *See id.* at 2-3 (referring to the prohibited conduct).

decree with the Antitrust Division (without a trial on the merits) that prohibited the hospitals from enforcing the agreement between them.[30]

- In Vermont, two home health agencies entered into anticompetitive territorial market allocations, facilitated by the state regulatory program, to give each other exclusive geographic markets.[31] Without the state's CON laws, competitive entry into these markets normally might have disciplined such cartel behavior. The Antitrust Division found that as a result, Vermont consumers were paying higher prices than were consumers in states where home health agencies competed against each other.[32]

Finally, the CON process itself may sometimes be susceptible to corruption. For example, as the task force is probably aware, in 2004, a member of the Illinois Health Facilities Planning Board was convicted for using his position on the Board to secure the approval of a CON application for Mercy Hospital. In exchange for his help, the Board member agreed to accept a kickback from the owner of the construction company that had been hired to work on the new hospital.[33]

3. Protecting Revenues of Incumbents Does Not Justify CON Laws

Incumbent hospitals often argue that they should be protected against additional competition so that they can continue to cross-subsidize care provided to uninsured or under-insured patients. Under this rationale, CON laws should impede the entry of new health care providers that consumers might enjoy (such as independent ambulatory surgery centers, free-standing radiology or radiation-therapy providers, and single- or multi-specialty physician-owned hospitals) for the express purpose of preserving the market power of incumbent providers. The providers argue that without CON laws, they would be deprived of revenue that otherwise could be put to charitable use.[34]

We fully appreciate the laudatory public-policy goal of providing sufficient funding for the provision of important health care services – at community hospitals and elsewhere

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[30] *Id.*

[31] Department of Justice Statement on the Closing of the Vermont Home Health Investigation (Nov. 23, 2005), *available at* http://www.usdoj.gov/atr/public/press_releases/2005/213248.htm.

[32] *Id.*

[33] Plea Agreement at 20-23, *U.S. v. Levine* (D. Ill. 2005) (No. 05-691).

[34] There is an ironic element to this argument: What started as laws intended to control costs have become laws intended to inflate costs. Proponents of CON laws now would use these barriers to entry to stifle competition, protect incumbent market power, frustrate consumer choice, and keep prices and profits high.

– to those who cannot afford them, and for whom government payments are either unavailable or too low to cover the cost of care. But at the same time, we want to be clear that the imposition of regulatory barriers to entry as an indirect means of funding indigent care may impose significant costs on all health care consumers – consumers who might otherwise benefit from additional competition in health care markets.

First, as noted above, CON laws stifle new competition that might otherwise encourage community hospitals to improve their performance. For example, in studying the effects of new single-specialty hospitals, the Medicare Payment Advisory Committee (MedPAC) found that certain community hospitals responded to competition by improving efficiency, adjusting their pricing, and expanding profitable lines of business.[35] In addition to administrative and operational efficiencies, the MedPAC Report identified several examples of improvements sparked by the entrance of a specialty hospital into a market, including extended service hours, improved operating room scheduling, standardized supplies in the operating room, and upgraded equipment.[36]

Second, we note that general CON requirements such as those imposed under Illinois law sweep very broadly, instead of targeting specific, documented social needs (such as indigent care). Although the Agencies do not suggest to Illinois policy makers any particular mechanism for funding indigent care, we note that solutions more narrowly tailored to the state's recognized policy goals may be substantially less costly to Illinois consumers than the current CON regime, and that the Lewin Group report commissioned by the state identifies various alternatives that may be more efficient in advancing such goals.[37]

Third, it is possible that CON laws do not actually advance the goal of maintaining indigent care at general community hospitals. Recently the federal government studied just this issue in connection with the emergence of single-specialty hospitals around the country. That study found that, for several reasons, specialty hospitals did not undercut the financial

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[35] *See, e.g.*, MEDPAC, *supra* note 19, at 10 ("Some community hospital administrators admit that competition with specialty hospitals has had some positive effects on community hospitals' operations"). Other studies have found that the presence of for-profit competitors leads to increased efficiency at nonprofit hospitals. Kessler, D. and McClellan M., "The Effects of Hospital Ownership on Medical Productivity," RAND Journal of Economics 33 (3), 488-506 (2002).

[36] MEDPAC, *supra* note 19, at 10; *see also* Greenwald, L. et al., "Specialty Versus Community Hospitals: Referrals, Quality, and Community Benefits," *Health Affairs* 25, no. 1 (2006): 116-117; Stensland J. and Winter A., "Do Physician-Owned Cardiac Hospitals Increase Utilization?" *Health Affairs* 25, no. 1 (2006): 128 (some community hospitals have responded to the presence of specialty hospitals by recruiting physicians and adding new cardiac catheterization labs).

[37] *See* Lewin Group, at 29 (discussing various financing options for charity care in Illinois).

viability of rival community hospitals.[38] One substantial reason for this was that specialty hospitals generally locate in areas that have above-average population growth. Thus, they are competing for a new and growing patient population, not just siphoning off the existing customer base of the community hospitals. This is consistent with the Lewin Group study showing that safety-net hospitals in non-CON states actually had higher profit margins than safety-net hospitals in CON states.[39]

III. Conclusion

The Agencies believe that CON laws impose substantial costs on consumers and health care markets and that their costs as well as their purported benefits ought to be considered with care. CON laws were adopted in most states under particular market and regulatory conditions substantially different from those that predominate today. They were intended to help contain health care spending, but the best available research does not support the conclusion that CON laws reduce such expenditures. As the Agencies have said, "[O]n balance, CON programs are not successful in containing health care costs, and . . . they pose serious anticompetitive risks that usually outweigh their purported economic benefits."[40] CON laws tend to create barriers to entry for health care providers who may otherwise contribute to competition and provide consumers with important choices in the market, but they do not, on balance, tend to suppress health care spending. Moreover, CON laws may be especially subject to abuse by incumbent providers, who can seek to exploit a state's CON process to forestall the entry of competitors in their markets. For these reasons, the Agencies encourage the task force to seriously consider whether Illinois's CON law does more harm than good.

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[38] MEDPAC, *supra* note 19, at 23-24; *see also* MedPAC, REPORT TO THE CONGRESS: PHYSICIAN-OWNED SPECIALTY HOSPITALS REVISITED, at 21-25 (August 2006), *available at* http://www.medpac.gov/documents/Aug06_specialtyhospital_mandated_report.pdf.

[39] Lewin Group, at 28.

[40] A DOSE OF COMPETITION, Executive Summary at 22.

Exhibit B

STATE OF CONNECTICUT
AGENCY LEGISLATIVE PROPOSAL
2009 SESSION

Document Name (e.g., OPM091.doc; OPM092.doc) OHCA091	
Agency Office of Health Care Access	**Agency Priority** (See instructions) Priority Number 1
Contact Person Carolyn Treiss Melanie Dillon	**Telephone** 418-7024 418-7060
Email Address Carolyn.Treiss@ct.gov Melanie.Dillon@ct.gov	
Title of Proposal AN ACT CONCERNING CERTIFICATES OF NEED AND ALSO HOSPITAL ASSESSMENT LATE FEES	**Statutory Reference** General Statutes §§ 19a-632, 19a-638, 19a-639, 19a-639a, 19a-639b and 19a-639c **Proposal Type** [X] New [ ] Resubmittal* (See below)
*If resubmittal: What happened? What was last action this past legislative session?	
ATTACH COPY OF FULLY DRAFTED BILL (Required for review)	

APPROVAL OF OTHER AFFECTED AGENCY (Attach additional approvals if necessary)	
Agency Department of Children and Families, Department of Public Health, Department of Mental Health and Addiction Services and Department of Social Services	**Agency Contact (Name and Title)** Susan Hamilton, Commissioner Karen Buckley-Bates, Director of Government Relations Doreen DelBianco, Legislative Program Manager Mark Schaeffer, Medical Policy and Behavioral Health Director
Attach Summary of Agency Comments	**Contact Date** September 22, 2008 – September 30, 2008

Office of Health Care Access

Legislative Session 2009

AN ACT CONCERNING CERTIFICATES OF NEED

Section 1. Subsection (e) of section 19a-632 of the general statutes is repealed and the following is substituted in lieu thereof:

(e) If any assessment [is not paid when due, a late fee of ten dollars shall be added thereto and interest at the rate of one and one-fourth per cent per month or fraction thereof shall be paid on assessment and late fee] remains unpaid within seven days of the date on which the assessment is due, a late fee of up to $1000.00 will be added to the total amount due.

Section 2. Subsection (a) (1) of section 19a-638 of the general statutes is repealed and the following is substituted in lieu thereof:

(1) Each health care facility or institution, that intends to (A) transfer [all or part of] its ownership or control, (B) change the governing powers of the board of a parent company or an affiliate, whatever its designation, or (C) change or transfer the powers or control of a governing or controlling body of an affiliate, shall submit to the office, prior to the proposed date of such transfer or change, a request for permission to undertake such transfer or change. For purposes of this section, "transfer its ownership" means a transfer that impacts or changes the governance or controlling body of a health care facility or institution, including, but not limited to, affiliations, mergers, or any sale or transfer of net assets of a health care facility or institution.

Section 3. Subsection (a) (4) of section 19a-638 of the general statutes is repealed and the following is substituted in lieu thereof:

(4) Except as provided in sections 19a-639a to 19a-639c, inclusive, each applicant, prior to submitting a certificate of need application under this section or section 19a-639, or under both sections, shall submit a request, in writing, for application forms and instructions to the office. The request shall be known as a letter of intent. A letter of intent shall include: (A) The name of the applicant or applicants; (B) a statement indicating whether the application is for (i) a new, replacement or additional facility, service or function, (ii) the expansion or relocation of an existing facility, service or function, (iii) a change in ownership or control, (iv) a termination of a service or a reduction in total bed capacity and the bed type, (v) any new or additional beds and their type, (vi) a capital expenditure over three million dollars, (vii) the purchase, lease or donation acceptance of

major medical equipment costing over three million dollars, (viii) a CT scanner, PET scanner, PET/CT scanner or MRI scanner, [cineangiography equipment], a linear accelerator or other similar equipment utilizing technology that is new or being introduced into the state, or (ix) any combination thereof; (C) the estimated capital cost, value or expenditure; (D) the town where the project is or will be located; and (E) a brief description of the proposed project. The office shall provide public notice of any complete letter of intent submitted under this section or section 19a-639, or both, by publication in a newspaper having a substantial circulation in the area served or to be served by the applicant. Such notice shall be submitted for publication not later than twenty-one days after the date the office determines that a letter of intent is complete. No certificate of need application will be considered submitted to the office unless a current letter of intent, specific to the proposal and in compliance with this subsection, has been on file with the office for not less than sixty days. A current letter of intent is a letter of intent that has been on file at the office up to and including one hundred twenty days, except that an applicant may request a one-time extension of a letter of intent of up to an additional thirty days for a maximum total of up to one hundred fifty days if, prior to the expiration of the current letter of intent, the office receives a written request to so extend the letter of intent's current status. The extension request shall fully explain why an extension is requested. The office shall accept or reject the extension request not later than seven days from the date the office receives such request and shall so notify the applicant.

Section 4. Subsection (a) of section 19a-639 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Except as provided in sections 19a-639a to 19a-639c, inclusive, each health care facility or institution, including, but not limited to, any inpatient rehabilitation facility, any health care facility or institution or any state health care facility or institution proposing (1) a capital expenditure exceeding three million dollars, (2) to purchase, lease or accept donation of major medical equipment requiring a capital expenditure, as defined in regulations adopted pursuant to section 19a-643, in excess of three million dollars, or (3) to purchase, lease or accept donation of a CT scanner <u>in excess of eight hundred thousand dollars</u>, PET scanner, PET/CT scanner or MRI scanner, [cineangiography equipment], a linear accelerator or other similar equipment utilizing technology that is new or being introduced into this state, including the purchase, lease or donation of equipment or a facility, shall submit a request for approval of such expenditure to the office, with such data, information and plans as the office requires in advance of the proposed initiation date of such project.

Section 5. Subsection (c) of section 19a-639 of the general statutes is repealed and the following is substituted in lieu thereof:

(c) Each person or provider, other than a health care or state health care facility or institution subject to subsection (a) of this section, proposing to purchase, lease, accept

donation of or replace (1) major medical equipment with a capital expenditure in excess of three million dollars, or (2) a CT scanner in excess of eight hundred thousand dollars, PET scanner, PET/CT scanner or MRI scanner, [cineangiography equipment], a linear accelerator or other similar equipment utilizing technology that is new or being introduced into the state, shall submit a request for approval of any such purchase, lease, donation or replacement pursuant to the provisions of subsection (a) of this section. In determining the capital cost or expenditure for an application under this section or section 19a-638, the office shall use the greater of (A) the fair market value of the equipment as if it were to be used for full-time operation, whether or not the equipment is to be used, shared or rented on a part-time basis, or (B) the total value or estimated value determined by the office of any capitalized lease computed for a three-year period. Each method shall include the costs of any service or financing agreements plus any other cost components or items the office specifies in regulations, adopted in accordance with chapter 54, or deems appropriate.

Section 6. Section 19a-639a of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Except as provided in subsection (c) of section 19a-639 of the 2008 supplement to the general statutes or as required in subsection (b) of this section, the provisions of section 19a-638 and subsection (a) of section 19a-639 of the 2008 supplement to the general statutes shall not apply to: (1) An outpatient clinic or program operated exclusively by, or contracted to be operated exclusively for, a municipality or municipal agency, a health district, as defined in section 19a-240, or a board of education; (2) a residential facility for the mentally retarded licensed pursuant to section 17a-227 of the 2008 supplement to the general statutes and certified to participate in the Title XIX Medicaid program as an intermediate care facility for the mentally retarded; (3) an outpatient rehabilitation service agency that was in operation on January 1, 1998, that is operated exclusively on an outpatient basis and that is eligible to receive reimbursement under section 17b-243; (4) a clinical laboratory; (5) an assisted living services agency; (6) an outpatient service offering chronic dialysis; (7) a program of ambulatory services established and conducted by a health maintenance organization; (8) a home health agency; (9) a clinic operated by the Americares Foundation; (10) a nursing home; or (11) a rest home. The exemptions provided in this section shall not apply when a nursing home or rest home is, or will be created, acquired, operated or in any other way related to or affiliated with, or under the complete or partial ownership or control of a facility or institution or affiliate subject to the provisions of section 19a-638 or subsection (a) of section 19a-639 of the 2008 supplement to the general statutes.

(b) Each health care facility or institution exempted under this section shall register with the office by filing the information required by subdivision (4) of subsection (a) of section 19a-638 for a letter of intent at least fourteen days but not more than sixty calendar days prior to commencing operations and prior to changing, expanding, terminating or relocating any facility or service otherwise

covered by section 19a-638 or subsection (a) of section 19a-639 of the 2008 supplement to the general statutes or covered by both sections or subsections, except that, if the facility or institution is in operation on June 5, 1998, said information shall be filed not more than sixty days after said date. Not later than fourteen days after the date that the office receives a completed filing required under this subsection, the office shall provide the health care facility or institution with written acknowledgment of receipt. Such acknowledgment shall constitute permission to operate or change, expand, terminate or relocate such a facility or institution or to make an expenditure consistent with an authorization received under subsection (a) of section 19a-639 of the 2008 supplement to the general statutes until the next September thirtieth. Each entity exempted under this section shall renew its exemption by filing current information once every two years in September.

(c) Each health care facility, institution or provider that proposes to purchase, lease or accept donation of a CT scanner, PET scanner, PET/CT scanner or MRI scanner, cineangiography equipment or a linear accelerator shall be exempt from certificate of need review pursuant to sections 19a-638 and 19a-639 of the 2008 supplement to the general statutes if such facility, institution or provider (1) provides to the office satisfactory evidence that it purchased or leased such equipment for under four hundred thousand dollars on or before July 1, 2005, and such equipment was in operation on or before July 1, 2006, or (2) obtained, on or before July 1, 2005, from the office, a certificate of need or a determination that a certificate of need was not required for the purchase, lease or donation acceptance of such equipment.

(d) The Office of Health Care Access shall, in its discretion, exempt from certificate of need review pursuant to sections 19a-638 and 19a-639 of the 2008 supplement to the general statutes any health care facility or institution that proposes to purchase or operate an electronic medical records system on or after October 1, 2005.

(e) Each health care facility or institution that proposes a capital expenditure for parking lots and garages, information and communications systems, physician and administrative office space, acquisition of land for nonclinical purposes, and acquisition and replacement of nonmedical equipment, including, but not limited to, boilers, chillers, heating ventilation and air conditioning systems, shall be exempt for such capital expenditure from certificate of need review under subsection (a) of section 19a-639 of the 2008 supplement to the general statutes, provided (1) the health care facility or institution submits information to the office regarding the type of capital expenditure, the reason for the capital expenditure, the total cost of the project and any other information which the office deems necessary; and (2) the total capital expenditure does not exceed twenty-million dollars. Approval of a health care facility's or institution's proposal for acquisition of land for nonclinical purposes shall not exempt such facility or institution from compliance with any of the certificate of need requirements prescribed in chapter

368z if such facility or institution subsequently seeks to develop the land that was acquired for nonclinical purposes.

(f) Each health care facility or institution that currently provides outpatient services, including, but not limited to, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, occupational injury management, occupational disease management and company contracted services, and proposes to provide any of the aforementioned services at another location within the primary service area of the health care facility or institution, shall be exempt for such proposal from certificate of need review under subsection (a) of section 19a-638 of the general statutes.

Section 7. Section 19a-639b of the general statutes is repealed and the following is substituted in lieu thereof:

(a) The Commissioner of the Office of Health Care Access or the commissioner's designee may grant an exemption from the requirements of section 19a-638 or subsection (a) of section 19a-639, or both, for any nonprofit facility, institution or provider that is currently under contract with a state agency or department and is seeking to engage in any activity, other than the termination of a service or a facility, otherwise subject to said section or subsection if:

(1) The nonprofit facility, institution or provider is proposing a capital expenditure of not more than three million dollars and the expenditure does not in fact exceed three million dollars;

(2) The activity meets a specific service need identified by a state agency or department with which the nonprofit facility, institution or provider is currently under contract;

(3) The commissioner, executive director, chairman or chief court administrator of the state agency or department that has identified the specific need confirms, in writing, to the office that (A) the agency or department has identified a specific need with a detailed description of that need and that the agency or department believes that the need continues to exist, (B) the activity in question meets all or part of the identified need and specifies how much of that need the proposal meets, (C) in the case where the activity is the relocation of services, the agency or department has determined that the needs of the area previously served will continue to be met in a better or satisfactory manner and specifies how that is to be done, (D) in the case where the activity is the transfer of all or part of the ownership or control of a facility or institution, the agency or department has investigated the proposed change and the person or entity requesting the change and has determined that the change would be in the best interests of the state and the patients or clients, and (E) the activity will be cost-effective and well managed; and

(4) In the case where the activity is the relocation of services, the Commissioner of the Office of Health Care Access or the commissioner's designee determines that the

needs of the area previously served will continue to be met in a better or satisfactory manner.

(b) The Commissioner of the Office of Health Care Access or the commissioner's designee may grant an exemption from the requirements of section 19a-638 or subsection (a) of section 19a-639, or both, for any nonprofit facility, institution or provider that is currently under contract with a state agency or department and is seeking to terminate a service or a facility, provided (1) the commissioner, executive director, chairperson or chief court administrator of the state agency or department with which the nonprofit facility, institution or provider is currently under contract confirms, in writing, to the office that the needs of the area previously served will continue to be met in a better or satisfactory manner and specifies how that is to be done, and (2) the Commissioner of the Office of Health Care Access or the commissioner's designee determines that the needs of the area previously served will continue to be met in a better or satisfactory manner.

(c) A nonprofit facility, institution or provider seeking an exemption under this section shall provide the office with any information it needs to determine exemption eligibility. An exemption granted under this section shall be limited to part or all of any services, equipment, expenditures or location directly related to the need or location that the state agency or department has identified.

(d) A nonprofit facility, institution or provider that is certified or will be certified as a psychiatric residential treatment facility (PRTF) for the treatment of children and adolescents under the age of 21 pursuant to 42 U.S.C. 1395aa, 42 U.S.C. 1396a and 42 U.S.C. 1396d and any applicable state laws and are currently under contract with a state agency or department are not eligible for exemptions granted pursuant to subsections (a) through (c) of this section.

[(d)] (e) The office may revoke or modify the scope of the exemption at any time following a public review that allows the state agency or department and the nonprofit facility, institution or provider to address specific, identified, changed conditions or any problems that the state agency, department or the office has identified. A party to any exemption modification or revocation proceeding and the original requesting agency shall be given at least fourteen calendar days written notice prior to any action by the office and shall be furnished with a copy, if any, of a revocation or modification request or a statement by the office of the problems that have been brought to its attention. If the requesting commissioner, executive director, chairman or chief court administrator or the Commissioner of Health Care Access certifies that an emergency condition exists, only forty-eight hours written notice shall be required for such modification or revocation action to proceed.

Section 8. Section 19a-639c of the general statutes is repealed and the following is substituted in lieu thereof:

Notwithstanding the provisions of section 19a-638 or section 19a-639, the office may waive the requirements of said sections and grant a certificate of need to any health

care facility or institution or provider or any state health care facility or institution or provider proposing to replace major medical equipment, a CT scanner, PET scanner, PET/CT scanner or MRI scanner, [cineangiography equipment] or a linear accelerator if:

(1) The health care facility or institution or provider has previously obtained a certificate of need for the equipment to be replaced; or

(2) The health care facility or institution or provider had previously obtained a determination pursuant to subsection (c) of section 19a-639a of the general statutes that a certificate of need was not required for the original acquisition of the equipment; and

(2) The replacement value or expenditure is less than three million dollars.

Summary of Agency Comments Regarding Proposed Changes to General Statutes § 19a-639b

The proposed changes to § 19a-639b would exclude PRTFs from exemptions under that section. In the course of discussions with DCF and DSS regarding the facilities that will seek certification as psychiatric residential treatment facilities, it is apparent that this is an emerging level of care and a special variety of residential treatment that will be provided in the state. PRTFs will require oversight by DCF and DSS and these agencies feel that OHCA's involvement in the process of health care facilities and institutions transitioning to this level of care is not only necessary but crucial to the successful introduction of PRTFs within the State of Connecticut.

We notified DMHAS to the extent that it could affect mental health facilities seeking exemptions pursuant to § 19a-639b. DMHAS indicated that the language should clearly state that PRTFs will provide treatment to adolescents and children under the age of 21, so that it would not affect any of their providers.

Exhibit C

Connecticut State Medical Society
FOUNDED IN 1792

160 St. Ronan Street, New Haven, CT 06511-2390 (203) 865-0587 FAX (203) 865-4997

June 2, 2008

Christine Vogel
Commissioner
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
Hartford, CT 06134

Dear Commissioner Vogel:

I am writing on behalf of the Connecticut State Medical Society ("CSMS") and the Connecticut Society of Eye Physicians, the Connecticut Society of Orthopedic Surgeons, and the Connecticut Society of Ear, Nose and Throat Physicians (the "Specialty Societies") in response to your request dated April 23, 2008, for input that may assist OHCA in the development of a definition of "CT Scanner".

In order to develop information for the CSMS and Specialty Societies response to your request, CSMS has consulted with the Specialty Societies and a number of its members, as well as with representatives of the Medical Imaging and Technology Alliance ("MITA").

CSMS believes that answers to the seven questions set forth in OHCA's April 23rd letter require a highly developed technical understanding of not only computerized tomography (or "computed" tomography, as defined by MITA), but also of the constantly evolving applications for that technology.

Accordingly, the CSMS endorses the definitions set forth in the MITA response dated May 30, 2008 to OHCA's letter, with the following observations and suggestions.

For a number of years, the physician community accommodated itself to the OHCA cost threshold for a certificate of need (CON). Although the cost threshold did not allow physicians to acquire many CT products without receiving a CON, the threshold did serve the purpose of generally allowing lower cost, limited-use scanning technologies to be owned and employed by physician practices, while the more expensive full-body CT scanners were owned and employed by hospitals and radiology groups, either separately or in joint ventures with one another.

Perhaps OHCA should consider a return to the cost threshold concept for computed tomography as number (8) in the list of what SHOULD NOT be considered subject to the CON process.

Accordingly, CSMS endorses the list of exceptions (1) through (7) proposed by MITA in its May 30th letter to OHCA, and suggests adding the following category (8):

(8) Any computed tomography equipment which has a purchase cost of less than $500,000.00.

Based on the information developed by MITA and the feedback CSMS has received from the Specialty Societies and individual physicians providing diagnostic and related services associated with this technology, it is clear that no patient care quality issues are implicated by the proposed definitions advocated by MITA and CSMS. To the contrary, once the utilization barriers have been eased, the evidence shows that patients receive better, more timely diagnosis and medical care through the use of CT technologies, at lower cost and in settings that are less restrictive and which patients prefer. Technology is changing rapidly and Connecticut regulations should acknowledge and reflect these changes and be able to adapt appropriately.

We thank you for this opportunity to provide this input into OHCA's rulemaking process, and look forward to working with you to closure on this matter for the betterment of patient medical care in the State of Connecticut..

Very truly yours,

Matthew C. Katz
Executive Director

Exhibit D

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 11, 2009

Mr. Matthew Katz
Executive Vice President
Connecticut State Medical Society
160 St. Ronan Street
New Haven, CT 06511

Dear Mr. Katz,

As you are aware, current Connecticut law requires Certificate of Need (CON) authorization for all acquisitions of computed tomography (CT) scanners. The Office of Health Care Access (OHCA) believes it is appropriate at this time to review how the law has operated since it went into effect in 2005. The agency is interested in learning from your experience with regard to the operation of the law as well as your expertise with this technology. In order for the law to operate in a way that appropriately reflects the nature of this technology, OHCA is convening a work group with the goal of providing recommendations to the OHCA Commissioner for possible use in the development of criteria and guidelines with which to evaluate CT scanners.

OHCA is requesting (1) your participation in the work group and (2) your designation of one physician from each of the following specialties to serve as work group members: ENT, Urology, Neurology and Orthopaedics.

OHCA anticipates that the group will complete its work in three successive monthly meetings. The first meeting will be held at OHCA's offices in Hartford on Tuesday, March 10, 2009 from 8:00 a.m. to 10:00 a.m. Two additional meetings are scheduled for Tuesday, April 7, 2009 and Tuesday, May 5, 2009 at the same time and location. Because of the specific nature of the meetings and the tight time frame in which to accomplish the work group's task, it is imperative that members commit to *personally* attend *all* meetings. OHCA respectfully requests that you do not have others sit in for you.

Please confirm your participation in the work group and provide your designees' names, addresses, phone numbers and email addresses to Marie Dempsey at marie.dempsey@ct.gov or (860) 418-7028 by Thursday, March 5, 2009. If you have questions or concerns, please contact Kim Martone at kimberly.martone@ct.gov or (860) 418-7029 or kaila.riggott@ct.gov or (860) 418-7037. Thank you in advance for your participation and cooperation.

Sincerely,

Cristine A. Vogel
Commissioner

Testimony of

The CT Dermatology and Dermatologic Surgery Society

The Connecticut ENT Society &

The Connecticut Society of Eye Physicians

on

SB 228 AN ACT CONCERNING A PERSONAL INCOME TAX DEDUCTION FOR INDIVIDUALS WHO RECEIVE ALL HEALTH SCREENINGS AS RECOMMENDED BY THE AMERICAN MEDICAL ASSOCIATION.

Presented to the Public Health Committee

By

Sumaira Aasi, M.D.

February 27, 2009

Good morning Senator Harris, Representative Ritter, and distinguished members of the Public Health Committee. My name is Dr. Sumaira Aasi, I am a board certified dermatologist practicing in New Haven and I am here to represent over 700 physicians in the fields of Dermatology, ENT and Eye medicine in support of SB 228 An Act Concerning a Personal Income Tax Deduction for Individuals Who Receive All Health Screenings as Recommended by the American Medical Association. I applaud the efforts of this committee for bringing this issue to public hearing and thank Senator Debicella for proposing legislation that rewards those who take part in action plans to improve their individual health and contribute to the reduction of health care costs for the nation.

By creating a tax deduction for healthier living, Connecticut takes a bold step in promoting proper preventative health care as defined by the American Medical Association. In conjunction with the AMA's recommendations for health screenings, the AMA promotes "Living a healthy lifestyle" -a campaign geared to reducing the risk of chronic diseases- which ultimately leads to the reduction of health care costs, by incorporating small changes into everyday life, like cutting 100 calories per day or using a parking lot farther from the work place to encourage 30 minutes of moderate exercise. These small steps-like the tax deduction proposed -can make the process of getting healthier more attractive and manageable.

In closing, I would like to thank this committee for their work in promoting preventative healthcare and as the weeks and months progress we look forward to working with you on some of the "Big Picture" issues affecting the health care delivery system in Connecticut.